Express Scripts Medicare™ (PDP)
Commonwealth of Virginia
Retiree Health Benefits Program

January 1 – December 31, 2014

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Express Scripts Medicare (PDP) for the Commonwealth of Virginia Retiree Health Benefits Program

This booklet gives you general information about your Medicare prescription drug coverage from January 1 – December 31, 2014. It explains how to get the prescription drugs you need covered.
This is an important legal document. Please keep it in a safe place. For specific plan information, please refer to your *Benefit Overview* and other plan materials.

This plan, **Express Scripts Medicare™** (PDP), is offered by Express Scripts Insurance Company or Medco Containment Life Insurance Company. (When this *Evidence of Coverage* says "we," "us" or "our," it means Express Scripts Insurance Company or Medco Containment Life Insurance Company. When it says "plan" or "our plan," it means Express Scripts Medicare.)

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

Express Scripts Medicare Customer Service: 1.800.572.4098 (TTY users call: 1.800.716.3231)

For more help or information, please contact Customer Service at the number above (also on the back of your member ID card) or go to our plan website at **http://www.Express-Scripts.com**. Calls to Customer Service are free. Customer Service is available 24 hours a day, 7 days a week. Customer Service has free language interpreter services available for non-English speakers.

This information is available in braille. Please contact Customer Service at the numbers above if you need plan information in another format.

This information is available for free in other languages. Please contact Customer Service at the numbers on the back of your member ID card and the front of this booklet for additional information. Customer service is available 24 hours a day, 7 days a week. Esta información está disponible sin cargo en otros idiomas. Comuníquese con el Servicio de atención al cliente de Express Scripts Medicare llamando a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio de atención al cliente está disponible las 24 horas, los 7 días de la semana.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2015.

2014 Evidence of Coverage

Table of Contents

Chapter 1. Getting started as a member of Express Scripts Medicare

SECTION 1 Introduction

Section 1.1 You are enrolled in Express Scripts Medicare, which is a Medicare prescription drug plan

Your former employer or your retiree group has chosen to get your Medicare prescription drug coverage through our plan, Express Scripts Medicare. In this booklet, "your former employer's plan" or "retiree group" means the Commonwealth of Virginia Retiree Health Benefits Program. Your "group benefits administrator" means your designated Commonwealth of Virginia Benefits Administrator. Your annual rate notification booklet from the Commonwealth of Virginia Retiree Health Benefits Program will include information to assist you in identifying your Benefits Administrator.

There are different types of Medicare plans. Express Scripts Medicare is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities and what is covered.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of Express Scripts Medicare.

Section 1.3 What does this chapter tell you?

Look through **Chapter 1** of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to Express Scripts Medicare?

If you are a new member, then it's important for you to learn how the plan operates — what the rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (contact information is listed on the front of this booklet and the back of your member ID card).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Express Scripts Medicare covers your care. Other parts of this contract include your eligibility record, the 2014 *Formulary (List of Covered Drugs)*, your *Benefit Overview*, your *Annual Notice of Changes* packet, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Express Scripts Medicare between January 1, 2014, and December 31, 2014.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Express Scripts Medicare after December 31, 2014. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2014, within the requirements of our contract with the Commonwealth of Virginia Department of Human Resource Management.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services, or CMS) must approve Express Scripts Medicare each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and remain in compliance with our contract with the Commonwealth of Virginia Department of Human Resource Management, your former employer continues to offer this plan, you remain eligible under your former employer's plan, and CMS renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (**Section 2.3** below describes our service area)
- You are entitled to Medicare Part A, or you are enrolled in Medicare Part B (or you have both Part A and Part B)
- Your former employer or your retiree group has submitted you for enrollment in this plan
- Medicare approves your enrollment

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).
- Medicare outpatient prescription drug coverage falls under Medicare Part D.

Section 2.3 Here is the plan service area for Express Scripts Medicare

Medicare is a Federal program. Express Scripts Medicare is available only to individuals who qualify for coverage from their former employer or retiree group and live in our plan service area. To stay a member of our plan, you must keep living in this service area. Our service area includes all 50 states, the District of Columbia, and Puerto Rico.

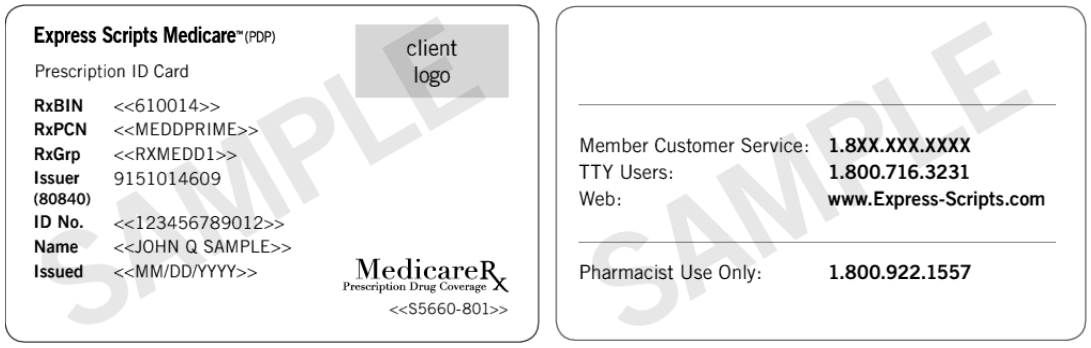
If you plan to move, please contact your group benefits administrator to update your address.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in **Chapter 2, Section 5.**

SECTION 3 What other materials will you get from us?

Section 3.1 Your member ID card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your member ID card for prescription drugs you get at network pharmacies. Below is a sample member ID card to show you what yours may look like, but **your card may look slightly different, and if you have been a member for several years, your card may still show the Medco Medicare Prescription Plan name. However, if you are an existing member, your card is still valid. Please continue to use your current card, as cards are not being re-issued for 2014.**



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (The phone number for Customer Service is listed on the back of your member ID card and on the front of this booklet.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare, Parts A and B. You will also have separate ID cards for your Medicare supplemental coverage and dental coverage, if applicable, in which you are enrolled through the Commonwealth of Virginia Retiree Health Benefits Program.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

How do I find participating network pharmacies?

Our *Pharmacy Directory* gives you a list of the retail network pharmacies closest to your address of record — that means the pharmacies in your area that have agreed to fill covered prescriptions for our plan members — as well as other pharmacies (such as long-term care pharmacies) in our network.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are listed on the front of this booklet and on the back of your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **http://www.Express-Scripts.com**.

Section 3.3 The plan's 2014 *Formulary (List of Covered Drugs)*

The plan has a *Formulary (List of Covered Drugs)* for the 2014 plan year. We call it the "Drug List" for short. It tells which commonly used Part D prescription drugs are covered by Express Scripts Medicare. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Express Scripts Medicare Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

Section 3.4 The *Explanation of Benefits* (the "EOB"): A summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or the EOB).

The EOB tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. **Chapter 4** (*Paying for your Part D prescription drugs*) gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB summary is also available upon request. To get a copy, please contact Customer Service. In addition to receiving your EOB in the mail, you may access a copy by visiting our website, **http://www.Express-Scripts.com**.

SECTION 4 Your monthly premium for Express Scripts Medicare

Section 4.1 Your plan premium

Your coverage is provided through contract with your former employer or your retiree group. Your premium for this coverage is a part of your total State Retiree Health Benefits Program premium if you are enrolled for this coverage. Your premium cost is provided in your annual rate notification materials from the Commonwealth of Virginia Retiree Health Benefits Program. If you have questions about your plan premium, please contact your group benefits administrator for more information.

If your former employer or your retiree group charges you a plan premium or a portion of the plan premium, you are required to pay the premium according to their instructions.

If your former employer or your retiree group has not received your plan premium when it is due, you will be notified of your past-due balance and the potential for termination of your coverage if not resolved.

If your membership is ended due to nonpayment of premiums, it will not affect your coverage under Medicare Parts A and B. Under your former employer's plan, you may not reinstate this coverage once it has been either declined or terminated.

However, if you think your membership has been wrongfully ended, please contact your group benefits administrator. **Chapter 7, Section 7** of this booklet tells how to make a complaint to Express Scripts Medicare. In addition, you must continue to pay any applicable Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include the Extra Help and State Pharmaceutical Assistance Programs. **Chapter 4** tells more about these programs. If you qualify, enrolling in one or both of these programs might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the information in your other plan documents may not apply to you.** We will send you a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you are getting Extra Help and you don't have the insert, please call Customer Service and ask for the Extra Help Rider. Phone numbers for Customer Service are listed on the back of your member ID card and on the cover of this booklet.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount charged by your former employer or retiree group. These situations are described below.

- Some members are required to pay a **late enrollment penalty (LEP)** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the LEP may be added to the monthly plan premium. If so, their monthly premium will be the monthly plan premium, plus the amount of their LEP.

    - If you are required to pay the LEP, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. **Chapter 4, Section 9** explains the LEP.

    - If you have an LEP and do not pay it, or it is not paid on your behalf, you could be disenrolled from the plan.

      Currently, the Commonwealth of Virginia Retiree Health Benefits Program does not collect an LEP, but if you have any LEP, it should still be resolved so that you do not pay a higher premium if you elect a Medicare Part D plan outside of the state program. The Commonwealth of Virginia Retiree Health Benefits Program can assist in resolving an LEP if the creditable coverage was under another state plan. Correspondence regarding an LEP will include additional information.

Many members are required to pay other Medicare premiums

In addition to paying your monthly plan premium, some members may be required to pay other Medicare premiums. Some plan members may pay a premium for Medicare Part A and some plan members may pay a premium for Medicare Part B, in addition to paying the monthly Part D plan premium.

Some people pay an extra amount for Part D because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government (not this plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and you will lose your prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not this plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to **Chapter 4, Section 10** of this booklet. You can also visit http://www.medicare.gov on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or you may call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

Your copy of *Medicare & You* 2014 gives information about the Medicare premiums in the section called "2014 Medicare Costs." This explains how the Part D premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You* 2014 from the Medicare website (http://www.medicare.gov). Or you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048.

Section 4.2 Can your former employer or your retiree group change your monthly plan premium during the year?

No. Your former employer or your retiree group is not allowed to change the amount it charges for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, you will be notified of the change in the fall and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program, or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with his or her prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward his or her monthly premium. And a member who loses his or her eligibility during the year will need to start paying his or her full monthly premium. You can find out more about the Extra Help program in **Chapter 4, Section 11.**

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your eligibility record, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from another employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If your name, address or phone number changes, please let us know by calling your group benefits administrator. To update other coverage, see below.

Read over the information we send you about any other insurance coverage you have

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see **Section 7** in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to **Chapter 6, Section 1.4** of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage in addition to this plan), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for a former employer or retiree group health plan coverage:

- If you have coverage based on former employment, Medicare pays first.
- If you also have coverage based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare unless you were already designated as Medicare primary when you became eligible due to ESRD.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 Express Scripts Medicare contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims or member ID card questions, please call or write to Express Scripts Medicare Customer Service. We will be happy to help you.

Customer Service	
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the front of this booklet.
WRITE	Express Scripts Medicare Express Scripts P.O. Box 14570 Lexington, KY 40512
WEBSITE	**http://www.Express-Scripts.com**

How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see **Chapter 7** (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see **Chapter 7** (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)). You may call us if you have questions about our coverage decision and appeals processes.

There are two types of coverage decisions and appeals: administrative and clinical. An administrative coverage decision or appeal occurs when the issue involves a decision about whether a medication is covered or not and at what cost-sharing amount. A clinical coverage decision or appeal occurs when the issue involves a decision about a restriction on a specific medication.

Initial Clinical Coverage Reviews (Including Prior Authorization Requests) for Part D Prescription Drugs	
CALL	**1.800.935.6103** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.877.329.3760**
WRITE	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
WEBSITE	**http://www.Express-Scripts.com**

Clinical Appeals for Part D Prescription Drugs	
CALL	**1.800.935.6103** Calls to this number are free. Our business hours are Monday through Friday, 7:00 a.m. to 6:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 7:00 a.m. to 6:00 p.m., Central Time.
FAX	**1.877.852.4070**
WRITE	Express Scripts Attn: Medicare Clinical Appeals P.O. Box 66588 St. Louis, MO 63166-6588
WEBSITE	**http://www.Express-Scripts.com**

Administrative Coverage Reviews and Appeals for Part D Prescription Drugs	
CALL	**1.800.413.1328** Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
FAX	**1.877.328.9660**
WRITE	Express Scripts Attn: Medicare Administrative Appeals P.O. Box 66587 St. Louis, MO 63166-6587
WEBSITE	**http://www.Express-Scripts.com**

How to contact us when you are making a complaint about the quality of care you have received, waiting times, Customer Service, or other concerns

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the previous section about making an appeal.) For more information on making a complaint, see **Chapter 7** (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Express Scripts contact information for filing a complaint	
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the front of this booklet.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.614.822.2099**
WRITE	Express Scripts Medicare Express Scripts Attn: Grievance Resolution Team P.O. Box 630035 Irving, TX 75063-0035
MEDICARE WEBSITE	You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit an online complaint to Medicare go to http://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests that ask us to pay a designated share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see **Chapter 5** (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See **Chapter 7** *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Express Scripts contact information for payment requests	
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the cover of this booklet.
FAX	**1.608.741.5483**
WRITE	Express Scripts P.O. Box 2858 Clinton, IA 52733-2858
WEBSITE	**http://www.Express-Scripts.com**

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease, also called ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare prescription drug plans, including our plan.

Medicare	
CALL	1.800.MEDICARE, or 1.800.633.4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, doctors, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. This plan will not be included in the summary from Medicare since it is not available to the entire Medicare population. You can also use the website to tell Medicare about any complaints you have about Express Scripts Medicare: **Tell Medicare about your complaint:** You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to http://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. You can call Medicare at the numbers above.

SECTION 3 State Health Insurance Assistance Program
(free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the SHIP listing located in the **Appendix** of this booklet to find information about the SHIP in your state.

A SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans. However, they will not have information about this plan.

SECTION 4 Quality Improvement Organizations
(paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) for each state. Please refer to the QIO listing located in the **Appendix** of this booklet to find information about the QIO in your state.

The QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact the QIO if you have a complaint about the quality of care you have received. For example, you can contact the QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

The Social Security Administration (SSA) is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security benefits, enrollment into Medicare is automatic. If you are not getting Social Security benefits, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and you have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Social Security Administration	
CALL	1.800.772.1213 Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency in your state (contact information is located in the **Appendix** of this booklet).

Chapter 3. Using the plan's coverage for your Part D prescription drugs

?

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Chapter 4, Section 11.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled, "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you don't have this notice and are receiving Extra Help, please call Customer Service and ask for the Extra Help Rider. (Note: The Extra Help Rider does not provide information on SPAP assistance.) Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

Your Part D prescription drugs are covered under our plan. This chapter explains rules for using your coverage for Part D drugs.

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* handbook.)

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See **Section 2,** *Fill your prescription at a network pharmacy or through the plan's home delivery service.*)
- Your drug must be on the plan's 2014 *Formulary (List of Covered Drugs)* (we call it the Drug List for short). (See **Section 3,** *The plan's Drug List,* for more information.)

- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. (See **Section 3,** *The plan's Drug List,* for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See **Section 2.5** for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory,* visit our website at **http://www.Express-Scripts.com**, or call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet) or use the *Pharmacy Directory.* You can also find information on our website at **http://www.Express-Scripts.com**.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Service.

- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations, or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service.

Section 2.3 Using the plan's home delivery service

For certain kinds of drugs, you can use the plan's network home delivery service. Generally, the drugs available through home delivery are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's home delivery service are marked as **mail-order drugs** (MO) in our Drug List.

To get order forms and information about filling your prescriptions by mail, either visit our website at **http://www.Express-Scripts.com** or call Customer Service at the numbers listed on the back of your member ID card and the front of this booklet.

Usually a home delivery pharmacy order will get to you in no more than 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a one-month supply and fill it at a retail network pharmacy while you wait for your home delivery supply to arrive. If your home delivery shipment is delayed, please call Customer Service at the numbers listed on the back of your member ID card and the front of this booklet. We'll make sure you have your medication when you need it.

Section 2.4 How can you get a maintenance supply of drugs?

When you get a maintenance supply of drugs, your cost-sharing amount may be lower. The plan offers two ways to get a long-term supply of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case, you will be responsible for the appropriate copayment or coinsurance for each (up to) 34-day supply. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at the numbers listed on the back of your member ID card and the front of this booklet for more information.
2. For certain kinds of drugs, you can use the plan's network **home delivery service. The drugs available through our plan's home delivery service are marked as "MO" (mail order) drugs in our Drug List.** See **Section 2.3** for more information about using our home delivery service.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling away from your local area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card and the front of this booklet to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug in a timely manner within your local area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our home delivery pharmacy service. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (**Chapter 5, Section 2.1** explains how to ask the plan to pay you back.)

SECTION 3 The plan's Drug List

Section 3.1 The Drug List tells which commonly used Part D drugs are covered

The plan has a 2014 *Formulary (List of Covered Drugs).* In this *Evidence of Coverage,* **we call it the Drug List for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, **Section 1.1** explains about Part D drugs).

We will generally cover a Part D drug on the Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either:*

- approved by the Food and Drug Administration (FDA). (That is, the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.)
- *– or –* supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see **Section 7.1** in this chapter). In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 How can you find out if a specific Part D drug is covered by the plan?

You have two ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Call Customer Service to find out if a particular drug is covered by the plan. Phone numbers for Customer Service are listed on the back of your member ID card or the front of this booklet.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The following sections tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you with the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your doctor has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. (Your share of the cost will usually be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor needs to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization.** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet) or check our website at **http://www.Express-Scripts.com**.

If there is a restriction for your drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your doctor would need to do to get coverage for the drug. Phone numbers for Customer Service are listed on the back of your member

ID card and the front of this booklet. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

What if the drug you want to take is not covered by the plan? For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered, but the brand-name version you want to take is not covered.

What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in **Section 4,** some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first.

What if the drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be? The plan puts covered drugs into different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is restricted, go to **Section 5.2** to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to **Section 5.3** to learn what you can do.

Section 5.2 What can you do if your drug is restricted in some way?

If your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your doctor time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer covered by the plan.**
- – *or* – the drug you have been taking is **now restricted in some way** (**Section 4** in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:** We will cover a temporary supply of a drug that you took during the prior plan year **during the first 90 days of the calendar year.** This temporary supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:** We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:** We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for at least 30 days, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

- **For those who have been a member of the plan for more than 90 days and reside in a long-term care facility and need a supply right away:** We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

Other times when we will cover at least a temporary 30-day transition supply (or less if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

To ask for a temporary supply, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor find a covered drug that might work for you. (Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.)

You can ask for an exception

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule. For example, you can ask the plan to cover a drug that is not currently covered. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your doctor want to ask for an exception, **Chapter 7, Section 5.4** tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 Your drug coverage can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to its drug coverage. For example, the plan might:

- **Add or remove drugs from coverage.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we will not cover it. Or we might remove a drug from coverage because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see **Section 4** in this chapter).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's drug coverage.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking,* the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from plan coverage. We will let you know of this change right away. Your doctor will also know about this change and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we stop covering a drug, but not because of a sudden recall or because a new generic drug has replaced it

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your cost or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug,** the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
    - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see **Chapter 7** (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your doctor will also know about this change and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D, and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to **Chapter 7, Section 5.5** in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label, as approved by the FDA.

- Generally, coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI, or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its off-label use.

Also, by law, these categories of drugs are not covered by Medicare Part D plans. Please review your formulary for drug coverage specifics.

- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs).
- Drugs, such as CAVERJECT®, CIALIS®, EDEX®, LEVITRA®, MUSE®, and VIAGRA®, when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs.

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. Please refer to your formulary or call Customer Service for more information. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the **Appendix** of this booklet.)

SECTION 8 Show your member ID card when you fill a prescription

Section 8.1 Show your member ID card

To fill your prescription, show your member ID card at the network pharmacy you choose. When you show your member ID card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your member ID card with you?

If you don't have your member ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share, but your out-of-pocket cost may be more. See **Chapter 5, Section 2.1** for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that explain the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that explain the rules for getting drug coverage.

Please Note: When beneficiaries enter, live in, or leave a skilled nursing facility, they are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (**Chapter 8,** *Ending your membership in this plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for at least 30 days, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that isn't on our Drug List, or if the plan has restrictions on its coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, **Chapter 7, Section 5.4** tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in Express Scripts Medicare doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Express Scripts Medicare in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or Express Scripts Medicare for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage (other than this plan)?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable, and the choices you have for drug coverage. (If the coverage from the Medigap policy is **creditable,** it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

If you have a Medigap plan and need to cancel your Commonwealth of Virginia plan coverage, contact your Benefits Administrator. (Your enrollment in this plan may automatically cancel any other Medicare prescription drug coverage in which you are enrolled.) Since all Commonwealth of Virginia Retiree Health Benefits Program Medicare-Coordinating Plans provide Medicare supplemental coverage and exclude any services received through a Medicare Advantage plan, you should carefully consider the value of other Medicare supplemental coverage in addition to your state plan coverage.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems, such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug for the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 10.2 A program to help members manage their medications

We have a Medication Therapy Management (MTM) program that can help our members with special situations. For example, some members have several complex medical conditions, or they may need to take many drugs at the same time, or they could have very high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. The program can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs or any problems you're having. You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.

If this program fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about this program, please contact Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

Chapter 4. Paying for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Section 11** of this chapter.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled, "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you don't have this notice and are receiving Extra Help, please call Customer Service and ask for the Extra Help Rider. (Note: The Extra Help Rider does not provide information on SPAP assistance.) Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your covered Part D prescription drugs at a network pharmacy. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in **Chapter 3,** not all drugs are Part D drugs — some drugs are covered under Medicare Part A or Part B and other drugs are excluded by law from Medicare coverage.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Examples of some of the materials where you can find more information about your specific plan include the *Annual Notice of Changes for 2014*, the *Benefit Overview*, the *Quick Reference Guide*, the 2014 *Formulary (List of Covered Drugs)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage.

Chapter 3 of this booklet. Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. **Chapter 3** also tells which types of prescription drugs are not covered by our plan.

The plan's *Pharmacy Directory.* In most situations, you must use a network pharmacy to get your covered drugs (see **Chapter 3** for the details). The *Pharmacy Directory* has a list of the closest retail pharmacies in the plan's network based on your address of record, as well as other pharmacies in the network. It also explains how you can get a maintenance supply of a drug (such as filling a prescription for a three-month supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on the plan selected by your former employer or your retiree group and which drug payment stage you are in when you get the drug

Section 2.1 What are the standard Part D drug payment stages?

As shown in the following table, there are typically four drug payment stages for your prescription drug coverage. The plan selected by your former employer or retiree group will determine if your plan has a Deductible or Coverage Gap stage and how these stages will apply (your *Benefit Overview* and other plan materials have more details). Not everyone reaches all stages in a plan year. Which stage you reach depends on how much you and the plan pay for covered drugs during the year.

How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind, you are always responsible for the plan's monthly premium, regardless of the drug payment stage you are in.

STAGE 1 *Yearly Deductible stage*	**STAGE 2** *Initial Coverage stage*	**STAGE 3** *Coverage Gap stage*	**STAGE 4** *Catastrophic Coverage stage*
If your plan has a deductible, you begin in this stage when you fill your first prescription of the plan year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid the deductible listed in other plan documents you have received. (More information on this stage is in **Section 4** of this chapter.)	During this stage, after you (or others on your behalf) have met your deductible, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Your share of the cost is shown in other plan documents you have received. You stay in this stage until your year-to-date **"total drug costs"** for covered drugs (your payments plus any Part D plan's payments) total $2,850. (More information on this stage is in **Section 5** of this chapter.)	Refer to other plan documents you have received to determine if your plan has a Coverage Gap and what you and the plan will pay during this stage. You stay in this stage until your year-to-date **out-of-pocket costs** (your payments) reach a total of $4,550. This amount and rules for counting costs toward this amount have been set by Medicare. (More information on this stage is in **Section 6** of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2014). (More information on this stage is in **Section 7** of this chapter.)

SECTION 3 We will send you an *Explanation of Benefits* (EOB) which explains payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Explanation of Benefits* (the EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **out-of-pocket** costs and includes what others have paid on your behalf.
- We keep track of your **total drug costs.** This is the amount you pay out-of-pocket and/or others pay on your behalf, plus the amount paid by the plan.

Our plan will prepare a written summary called the *Explanation of Benefits* (it is sometimes called the EOB) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows your total drugs costs, including what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs for the year since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to **Chapter 5, Section 2** of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchased a covered drug at a network pharmacy at a special price or used a discount card that was not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for the Catastrophic Coverage stage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 If the Deductible stage applies to your former employer or your retiree group plan, you pay the full cost of your drugs during this stage

Section 4.1 If your plan has a Deductible stage, you stay in this stage until you have paid the amount listed in your *Benefit Overview* and other plan documents you have received

If your plan does not have a deductible, please skip to Section 5.

The Deductible stage is the first payment stage for your drug coverage. This stage begins when you fill your first applicable prescription of the plan year. You will pay a yearly deductible in the amount listed in your *Benefit Overview* and other plan documents you have received. When you are in this payment stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount. Please refer to your *Benefit Overview* and other plan documents you have received to determine the amount of your deductible and to which types of drugs your deductible applies (in this plan, it only applies to covered brand-name drugs, not generics).

- Your **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **deductible** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid the applicable deductible, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

SECTION 5 During the Initial Coverage stage, the plan pays its share of your drug costs, and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost may vary, depending on the drug and where you fill your prescription.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's home delivery pharmacy

For more information about these pharmacy choices and filling your prescriptions, see **Chapter 3** in this booklet and the plan's *Pharmacy Directory.*

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies.

Section 5.2 Your costs for covered Part D drugs

During the Initial Coverage stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **Copayment** means that you pay a fixed amount each time you fill a prescription.
- **Coinsurance** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in other plan documents you have received, the amount of the copayment or coinsurance also depends on which tier your drug is in.

- If your covered drug costs less than the copayment amount listed in your *Benefit Overview* or other plan materials, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*
- We cover prescriptions filled at out-of-network pharmacies only in limited situations. Please see **Chapter 3, Section 2.5** for information about when we will cover a prescription filled at an out-of-network pharmacy.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of an entire month's supply

Typically, you pay a copayment or coinsurance to cover a full month's supply (up to a 34-day supply) of a covered drug. However, your doctor can prescribe less than a full month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees to prescribe less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount). Daily cost-sharing under this plan applies as follows:

- A Tier 1 or Tier 2 drug: Since you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- A Tier 3 or Tier 4 drug: Since you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will generally be lower if you get less than a full month's supply, the *amount* you pay will be less.

Here's an example:

- Let's say the copayment for your drug for a full month's supply (a 34-day supply) is $34. This means that the amount you pay per day for your drug is $1. If you receive a 7-day supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total copayment of $7.

- You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 27 days more of the drug, you will still pay $1 per day, or $27. Your total cost for the month will be $7 for your first prescription and $27 for your second prescription, for a total of $34 — the same as your copayment would be for a full month's supply.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

Section 5.4 You stay in the Initial Coverage stage until your total drug costs for the year reach $2,850

You stay in the Initial Coverage stage until the total amount for the prescription drugs you have filled and refilled reaches the **$2,850 limit for the Initial Coverage stage.**

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See **Section 6.2** for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The deductible you paid when you were in the Deductible stage (if applicable).
  - The total you paid (including amounts paid on your behalf) as your share of the cost for your drugs during the Initial Coverage stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage stage. (If you were enrolled in a different Part D plan at any time during 2014, the amount that plan paid during the Initial Coverage stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $2,850 limit in a year.

We will let you know if you reach this $2,850 amount. If you do reach this amount, you will leave the Initial Coverage stage and move on to the Coverage Gap stage.

Please refer to your *Benefit Overview* or other plan materials for your plan-specific coverage in the Initial Coverage stage.

If your plan does not have a Coverage Gap stage, you will remain in the Initial Coverage stage until your total out-of-pocket costs reach $4,550. Once you reach this amount, you will move into the Catastrophic Coverage stage.

SECTION 6 Refer to your *Benefit Overview* or other plan materials to see what you pay and what the plan pays during the Coverage Gap stage

Section 6.1 You stay in the Coverage Gap stage until your out-of-pocket costs reach $4,550

When you are in the Coverage Gap stage, **you pay what is shown in your *Benefit Overview* and other plan materials** for this stage until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2014, that amount is $4,550.

Please refer to your *Benefit Overview* and other plan materials to determine if your plan has a Coverage Gap stage. If your plan does have a Coverage Gap stage, your other plan materials will indicate if any additional coverage is provided while in this stage.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D enrollees who have a total drug cost of $2,850 and are not already receiving Extra Help. This total drug cost amount provides access to the discount program even if your plan does not have a Coverage Gap stage that results in your paying the full cost of your drugs. A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand-name drugs from manufacturers that have agreed to provide the discount. (Drugs manufactured by non-participants are not Part D drugs.) Once the manufacturer discount is applied, you pay your designated copayment or coinsurance (or the balance of the cost, if applicable), and the plan pays the rest.

If you reach the Coverage Gap, we will automatically apply the discount when your pharmacy charges you for your prescription, and your *Explanation of Benefits* (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the Coverage Gap.

You also usually pay the same copayment for generic drugs in the Coverage Gap that you received in the Initial Coverage stage except that in 2014 you will pay no more than 72% of the drug cost. The coverage for generic drugs works differently than the 50% discount for brand-name drugs. For generic drugs, the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the Coverage Gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

See your other plan materials for the specifics of your coverage during the Coverage Gap stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in **Chapter 3** of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible stage
  - The Initial Coverage stage
  - The Coverage Gap stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself,** they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Payments made by the Medicare Coverage Gap Discount Program are included. Since the Medicare Coverage Gap Discount Program does not cover generics, the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage stage:

When you (or those paying on your behalf) have spent a total of $4,550 in out-of-pocket costs within the calendar year, you will move on to the Catastrophic Coverage stage.

*These payments are **not** **included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Any premium cost
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments made by the plan during the Coverage Gap stage
- Payments for your drugs that are made by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are listed on the back of your member ID card and the front of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* (EOB) summary we send to you includes the current amount of your out-of-pocket costs (**Section 3** in this chapter tells about this report). When you reach a total of $4,550 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage stage.
- **Make sure we have the information we need. Section 3.2** tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage stage when your out-of-pocket costs have reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - *–either –* coinsurance of 5% of the cost of the drug
  - *–or –* a $2.55 copayment for a generic drug or a drug that is treated like a generic. Or a $6.35 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

The amounts above are the standard Medicare Part D cost-sharing amounts. Please refer to your *Benefit Overview* or other plan documents you have received to determine if your plan-specific coverage varies. In rare circumstances, your out-of-pocket cost during the Catastrophic Coverage stage could be more than you paid in the Initial Coverage and Coverage Gap stages.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself.** The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for)
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's 2014 *Formulary (List of Covered Drugs).*
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication**
3. **Who gives you the vaccination shot**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Your actual costs may vary in each stage, depending on your plan design.

Situation 1: You buy the Part D vaccine at the network pharmacy and you get your vaccination shot at a network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and administration of the vaccine.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in **Chapter 5** of this booklet (*Asking us to pay our share of the costs for covered drugs*).
- You will be reimbursed the amount you paid, less your normal coinsurance or copayment for the vaccine and administration.

Situation 3: You buy the Part D vaccine at a network pharmacy and then take it to your doctor's office, where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in **Chapter 5** of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are listed on the back of your member ID card and the front of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D late enrollment penalty (LEP)?

Section 9.1 What is the Part D LEP?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the LEP rules do not apply to you. You will not pay an LEP, even if you have gone without "creditable" prescription drug coverage.

You or your former employer or your retiree group may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty may be added to your monthly premium. When you first enroll in Express Scripts Medicare, we let you know the amount of the penalty. If you are responsible for an LEP, it is considered to be part of your plan premium. In this plan at this time, you will not be asked to pay an LEP, but in other plans, if your LEP is not paid, you could be disenrolled for failure to pay your plan premium. Your other plan materials will include additional information.

Section 9.2 How much is the Part D LEP?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare prescription drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2013, this average premium amount was $31.17. This amount may change for 2014.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $31.17, which equals $4.36. This rounds to $4.40. This amount would be added **to the monthly premium amount for someone with an LEP.**

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the LEP will reset when you turn 65. After age 65, your LEP will be based only on the months that you don't have coverage after your Initial Enrollment Period for aging into Medicare.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, there are times when you may not have to pay the LEP.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **creditable drug coverage.**
- Please note:
    - Creditable coverage could include drug coverage from a former employer or retiree group, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You* 2014 handbook or call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 9.4 What can you do if you disagree about your LEP?

If you disagree about your LEP, you or your representative can ask for a review of the decision about your LEP. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay an LEP. Call Customer Service at the numbers listed on the back of your member ID card or on the front of this booklet to find out more about how to do this.

Important: Do not stop paying your LEP while you're waiting for a review of the decision about your LEP. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people will pay their plan's total monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless you don't have a monthly benefit or your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately. **This amount is not charged by this Part D plan, it is charged by the Federal government. It cannot be paid with your monthly premium for this plan.**

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your Internal Revenue Service (IRS) tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The following chart shows the extra amount based on your income.

If you filed an individual tax return and your income in 2012 was:	**If you were married but filed a separate tax return and your income in 2012 was:**	**If you filed a joint tax return and your income in 2012 was:**	**This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)**
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$12.10
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$31.10
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$50.20
Greater than $214,000	Greater than $129,000	Greater than $428,000	$69.30

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1.800.772.1213. Automated services are available 24 hours a day, 7 days a week. You can speak with a representative between 7 a.m. and 7 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778 between 7 a.m. and 7 p.m., Eastern Time, Monday through Friday.

Section 10.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 11 Information about programs to help people pay for their prescription drugs

Medicare's Extra Help Program

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you may get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1.800.772.1213, between 7:00 a.m. and 7:00 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778; or
- Your State Medicaid Office. (See the **Appendix** of this booklet for contact information.)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

We may be able to accept one of the following forms of Best Available Evidence (BAE) to establish that you qualify for Extra Help, when the evidence is provided by you or your pharmacist, advocate, representative, family member, or other individual acting on your behalf:

1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during any month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during any month after June of the previous calendar year;
3. A printout from the state electronic enrollment file showing Medicaid status during any month after June of the previous calendar year;
4. A screen print from the state's Medicaid systems showing Medicaid status during any month after June of the previous calendar year;
5. Other documentation provided by the state showing Medicaid status during any month after June of the previous calendar year;
6. A letter from SSA showing that the individual receives Supplemental Security Income (SSI); or,
7. An Application Filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605)

The following proofs of institutional status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized, beginning on a date specified by the Secretary of the Department of Health and Human Services (HHS):

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during any month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;
3. A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar-month stay for Medicaid payment purposes during any month after June of the previous calendar year.

The following proofs of status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary to establish that an individual is receiving home and community based services (HCBS) and qualifies for zero cost-sharing effective as of a date specified by the Secretary of HHS:

1. A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
2. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
3. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
4. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,
5. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

You or your representative may fax or mail Best Available Evidence to the following fax number or address:

Fax: **1.855.297.7271**
Address: **Express Scripts Medicare PDP**
P.O. Box 4558
Scranton, PA 18505

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service at the numbers on the front of this document if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand-name drugs in the Coverage Gap stage. The 50% discount and the 2.5% paid by the plan are applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts from the Coverage Gap Discount Program?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the Coverage Gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the Coverage Gap and did not get a discount when you paid for your brand-name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn’t appear on your EOB, you should contact us to make sure that your prescription records are correct and up to date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in the **Appendix** of this booklet) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

State Pharmaceutical Assistance Programs (SPAPs)

Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members. These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Contact information for State Pharmaceutical Assistance Programs (SPAPs) is located in the **Appendix** of this booklet.

Chapter 5. Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to **Chapter 7** of this booklet).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to **Chapter 3, Section 2.5** to learn more.)

- Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your member ID card with you

If you do not have your member ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you need to pay if you do not have your member ID card.

- Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's Drug List, or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- If you are requesting payment for coverage of a Part D vaccine, such as a vaccine drug or administration of a vaccine drug, please save your invoice (bill) from your doctor and send a copy to us when you ask us to pay you back for our share of the cost.
- In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

5. In a medical emergency

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When traveling away from your local area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card and the front of this booklet to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area that can dispense your drug, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled outside the United States, even for a medical emergency.

7. To obtain a covered drug in a timely manner

In some cases, you may be unable to obtain a covered drug in a timely manner within your local area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

8. If a network pharmacy does not stock a covered drug

Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our home delivery pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. **Chapter 7** of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with a copy of your pharmacy prescription receipt or your pharmacy patient history printout signed by the dispensing pharmacist. A copy of an invoice (bill) is required for all other requests for payment, such as claims for vaccines from a physician or claims for Medicare Part D drugs from a hospital or clinic. It's a good idea to keep the original receipts or invoices, or to make copies, for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website, **http://www.Express-Scripts.com**, or call Customer Service and ask for a "Direct Claim Form." The phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet.

Mail your request for payment, together with any receipts, to us at this address:

Express Scripts
ATTN: Med D Claims
P.O. Box 2858
Clinton, IA 52733-2858

You also have the option of faxing your claim form and receipts to **1.608.741.5483.**

You must submit your claim to us within 36 months of the date you received the service, item or drug.

Please be sure to contact Customer Service if you have any questions. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will review your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (**Chapter 3** explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 14 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested, and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a covered prescription filled
- When you pay the full cost for a covered prescription because you don't have your member ID card with you
- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to **Chapter 7** of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading **Section 4** of **Chapter 7. Section 4** is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read **Section 4,** you can go to **Section 5.5** in **Chapter 7** for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**
   Sometimes when you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan), you may be able to buy your drug **at a pharmacy** for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
   - Save your receipt and send a copy to us so that we can have your qualifying out-of-pocket expenses count toward the Catastrophic Coverage stage.

- **Please note:** If you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan and the plan does not provide coverage in the gap), we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and will count toward qualifying for the Catastrophic Coverage stage.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and will count toward qualifying for the Catastrophic Coverage stage.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, or in other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English-speaking members. We can also give you information in braille or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1.877.486.2048.

Sección 1.1 Debemos brindar información de tal forma que le sea útil (en español, en braille, o otros formatos alternativos, etc.)

Para obtener información nuestra de tal forma que le sea útil, llame al Servicio al Cliente (los números de teléfono están en la portada de este folleto).

Nuestro plan cuenta con servicios disponibles de intérprete de idiomas sin cargo y personas para responder preguntas de miembros que no hablan inglés. Además, podemos brindarle información en braille u otros formatos alternativos si a necesita. Si es elegible para Medicare debido a una incapacidad, debemos brindarle información sobre los beneficios del plan que es accesible y adecuado para usted.

Si tiene problemas para obtener información de nuestro plan debido a problemas relacionados con el idioma o incapacidad, llame a Medicare al 1.800.MEDICARE (1.800.633.4227), las 24 horas del día, los 7 días de la semana, e infórmeles que desea presentar una queja. Los usuarios de TTY deben llamar al 1.877.486.2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users call 1.800.537.7697). You can also visit their website at http://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, **Chapter 7, Section 7** of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, **Chapter 7, Section 4** tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information we received when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice in your initial Welcome Kit, called a *Notice of Privacy Practices,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make health care decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your doctor to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of Express Scripts Medicare, you have the right to get several kinds of information from us. (As explained in **Section 1.1,** you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, in braille, or in other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet):

- **Information about our plan**

  This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members.

- **Information about our network pharmacies**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the retail pharmacies in your area and others that are in the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet) or visit our website at **http://www.Express-Scripts.com**.

- **Information about your coverage and rules you must follow in using your coverage**
  - To get the details on your Part D prescription drug coverage, see **Chapters 3** and **4** of this booklet. These chapters, together with the 2014 *Formulary (List of Covered Drugs)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

- **Information about why something is not covered and what you can do about it**
  - If your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are dissatisfied with your plan, or if you disagree with a decision we make about how a Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see **Chapter 7** of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (**Chapter 7** also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see **Chapter 5** of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you become unable to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives.** There are different types of advance directives and different names for them. Documents called a **living will** and a **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate agency in your state, such as the Department of Health.

Many advance directives only delegate authority if you are determined to be unable to make your own health care decisions. If you are not determined to be unable to make you own decisions, the designee does not have authority to make decisions on your behalf.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, **Chapter 7** of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in **Chapter 7,** what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users call 1.800.537.7697). You can also visit their website at http://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- Or, **you can call Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**

- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication, "Your Medicare Rights and Protections." Go to http://www.medicare.gov/Publications and enter in publication ID 11534 to download a PDF of the publication.
  - Or, you can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this* Evidence of Coverage *booklet along with your formulary and other plan documents you have received to learn what is covered for you and the rules you need to follow to get your covered drugs.*
  - **Chapters 3** and **4** give the details about your coverage for Part D prescription drugs.

- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Customer Service to let us know (phone numbers are listed on the back of your member ID card and the front of this booklet).*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **coordination of benefits** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to **Chapter 1, Section 7.)**

- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your member ID card whenever you get your Part D prescription drugs.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - If you are responsible for a premium, you must pay it to continue being a member of this plan.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Other plan documents you have received will tell you what you must pay for your Part D prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see **Chapter 7** of this booklet for information about how to make an appeal.
    - In most Part D plans, if you are required to pay a late enrollment penalty (LEP), you must pay the penalty to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call your group benefits administrator.*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (**Chapter 1** tells about our service area.)
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you. Contact your group benefits administrator to update your address.
    - If you move, it is also important to tell Social Security. You can find the phone numbers and contact information for Social Security in **Chapter 2.**

- ***Call Customer Service for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
    - Phone numbers and hours of operation for Customer Service are listed on the back of your member ID card and the front of this booklet.
    - For more information on how to reach us, including our mailing address, please see **Chapter 2.**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Background

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- One for **getting coverage decisions and making appeals**
- And another process **for making complaints**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in **Section 3** will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program (SHIP).** This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in the **Appendix** of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, read the parts of this chapter that apply to your situation. The guide that follows on the next page will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered, and problems related to payment for prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and appeals.**	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, Customer Service, or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are listed on the back of your member ID card and the front of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see **Section 2** of this chapter for more information).
- **If your concern is about coverage of Part D prescription drugs,** your doctor or other prescriber can request a coverage decision or a Level 1 or 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service (phone numbers for Customer Service are listed on the back of your member ID card and the front of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read **Section 4** of this chapter, *A guide to the basics of coverage decisions and appeals?* If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to the 2014 *Formulary (List of Covered Drugs).* To be covered, the drug must be included in our plan's formulary and must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the 2014 *Formulary (List of Covered Drugs),* rules and restrictions on coverage, and cost information, see **Chapter 3** (*Using the plan's coverage for your Part D prescription drugs*) and **Chapter 4** (*Paying for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in **Section 4** of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal terms	An initial coverage decision about your Part D drugs is called a **coverage determination.**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's 2014 *Formulary (List of Covered Drugs)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

- You ask us not to enforce a coverage rule. (For example, when your drug is covered by the plan, but we require you to get approval from us before we will cover it for you.)
    - Please note: If your pharmacy tells you that your prescription cannot be covered as written, you will get a written notice from the pharmacy explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a Part D drug that isn't on our Drug List or want us to waive a rule or restriction on a drug we cover?	**Do you want us to cover a Part D drug that isn't on our Drug List and you believe you have met any plan rules or restrictions (such as getting approval in advance) for the drug you need?**	**Do you want to ask us to pay you back for a drug you have already received and paid for?**	**Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?**
You can ask us to make an exception. (This is a type of coverage decision.)	You can ask us for a coverage decision.	You can ask us to pay you back. (This is a type of coverage decision.)	You can make an appeal. (This means you are asking us to reconsider.)
Start with **Section 5.2** of this chapter.	Skip ahead to **Section 5.4** of this chapter.	Skip ahead to **Section 5.4** of this chapter.	Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Formulary (List of Covered Drugs).** (We call it the Drug List for short.)

Legal terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in our Non-Preferred Brand Tier (Tier 3). You cannot ask for another exception to the coinsurance amount we require you to pay for the drug.

- Generally, you cannot ask for coverage of any "excluded drugs," or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see **Chapter 3.**)

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs we cover (for more information, go to **Chapter 3**).

Legal terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for an **exception.**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called **prior authorization.**)
  - *Being required to try a different drug first* before we agree to cover the drug you are asking for. (This is sometimes called **step therapy.**)
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- If your plan has a Specialty Tier, you cannot ask us to change the cost-sharing tier for any drug in this tier.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in a specific cost-sharing tier. You can see what tier a drug is in by looking in your 2014 *Formulary (List of Covered Drugs)*. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

- If your drug is in our Non-Preferred Brand Tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand Tier. This would lower your share of the cost for the drug.

- If your plan has a Specialty Tier, you cannot ask us to change the cost-sharing tier for any drug in this tier.
- You cannot ask us to cover a preferred brand drug as a generic drug.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our plan's coverage includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for a formulary or tiering exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. **Section 5.5** tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1 You ask us to make a coverage decision about the drug(s) or payment you need.
If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access information about the coverage decision process through our website. For the details, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost of a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** of this chapter tells how you can give written permission to someone else to act as your representative. You can also give permission to a lawyer to act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading **Chapter 5** of this booklet: *Asking us to pay our share of the costs for covered drugs.* **Chapter 5** describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the supporting statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See **Sections 5.2** and **5.3** for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

If your health requires it, ask us to give you a fast decision

Legal terms	A fast decision is called an **expedited coverage determination.**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast decision *only* if using *the standard deadlines could cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast decision, we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

Step 2 We consider your request and we give you our answer.

Deadlines for a **fast** coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a **standard** coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a **written statement** that explains why we said no and how to appeal our decision.

Deadlines for a **standard** coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3 If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our plan)

Legal terms	An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.**

Step 1 You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **fast appeal.**

What to do

- **To start your appeal, you, your doctor, or your representative must contact us.**
    - For details on how to reach us by phone, fax, or mail, for any purpose related to your appeal, go to **Chapter 2, Section 1,** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in **Chapter 2, Section 1** (*How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*)
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone numbers shown in Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a fast appeal

Legal terms	A fast appeal is also called an **expedited reconsideration.**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast decision in **Section 5.4** of this chapter.

Step 2 We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a **fast appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a **standard appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay **you back for a drug** you already bought, we are required to **send payment to you within 30 calendar days after we receive** your appeal request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3 If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal terms	The formal name for the Independent Review Organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for **fast appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for **standard appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3 If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. **Section 6** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D drug appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal and make a decision.

- This is the last step of the appeals process.

Making complaints

SECTION 7 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to **Section 4** of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of the following kinds of problems or concerns, you can make a complaint:

- If you are unhappy with the quality of care received
- If you feel someone did not respect your right to privacy or has shared information you feel should be confidential
- If you feel someone treated you disrespectfully
- If you received poor Customer Service
- If you feel you are being encouraged to leave the plan
- If you were kept waiting too long at the pharmacy or by Customer Service
- If you are unhappy with the condition or cleanliness of the pharmacy
- If you feel we have not given you a notice we are required to give or that written information was too difficult to understand

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals:

The process of asking for a coverage decision and making appeals is explained in **Sections 4-6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for making a complaint is filing a grievance

Legal terms

- What this section calls a **complaint** is also called a **grievance.**
- Another term for **making a complaint** is **filing a grievance.**
- Another way to say **using the process for complaints** is **using the process for filing a grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1 Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the phone numbers listed on the back of your member ID card and the front of this booklet.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
    - If you have a complaint or grievance, you or your representative may call Customer Service at the phone numbers listed on the back of your member ID card and the front of this booklet. An attempt will be made to resolve your complaint over the phone. If you ask for a written response or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. This process is called "Express Scripts Medicare Complaints and Grievances." Regarding expedited processing for initial determinations and redeterminations, Express Scripts approves requests either orally or in writing within the timeframes outlined in **Section 5.4** of this chapter for coverage determinations and in **Section 7.3** of this chapter for complaints.
    - If you prefer to state your grievance in writing, please send a grievance form or a letter with as much detail as possible to: Express Scripts Medicare, Express Scripts, Attn.: Grievance Resolution Team, P.O. Box 630035, Irving, TX 75063-0035. All grievances received in writing will be responded to in writing.
- **Whether you call or write, you should file your complaint right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a fast response to a coverage decision or appeal, we will automatically give you a fast complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal terms	What this section calls a **fast complaint** is also called an **expedited grievance.**

Step 2 We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two additional options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in the **Appendix** of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

Chapter 8. Ending your membership in this plan

Note: This chapter contains general information on disenrollment from a Medicare Part D plan and member options. For specific options available to you as a member of a group sponsored plan or for more information, please contact your group benefits administrator.

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in this plan

Ending your membership in Express Scripts Medicare may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave this plan because you have decided to end your membership or you are no longer eligible.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in many Medicare Part D plans. **Section 2** tells you *when* you can generally end your membership in some plans. **However, as a member of a group sponsored plan (such as this plan), you may end your membership in this plan at any time throughout the year and you will be granted a Special Enrollment Period to enroll in other coverage.**
    - The process for voluntarily ending your membership varies, depending on what type of new coverage you are choosing. **Section 3** tells *you how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. **Section 5** tells you about situations when we must end your membership.

If you are leaving this plan, you must continue to get your covered Part D prescription drugs through this plan until your membership ends.

SECTION 2 When can you end your membership in this plan?

As explained above, you can end your membership in this plan prospectively at any time. In many Medicare Part D plans, you may only end your membership during certain times of the year, known as enrollment periods. All members have the opportunity to leave their plan during the Medicare Annual Enrollment Period.

The remainder of Section 2 addresses Medicare Part D plans available to all Medicare beneficiaries and does not apply to this plan.

Section 2.1 Usually, you can end your membership during the Medicare Annual Enrollment Period

In some plans, you can only end your membership during the **Medicare Annual Enrollment Period** (also known as the Annual Coordinated Election Period). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year. In certain types of plans, you may also be eligible to leave the plan at other times of the year (see above).

- **When is the Medicare Annual Enrollment Period?** This happens from October 15 to December 7 every year. **Some employers or retiree groups may have established an open enrollment period with different timing during which you may elect changes. Please contact the appropriate group benefits administrator for more information about any former employer or your retiree group-established open enrollment periods. (This plan does not have an open enrollment period.)**
- **When will your membership end? If you enroll in other Part D coverage,** your membership in this plan will end when your new plan's coverage begins on January 1. If you enroll in another plan during this period, it will cause your second election to end.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, Medicare beneficiaries may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.** As a member of a group sponsored plan, you may end your membership in this plan at any time during the year and you will qualify for a Special Enrollment Period.

- **Who is eligible for a Special Enrollment Period?** For most Medicare Part D plans, you are eligible to end your membership during the Special Enrollment Periods listed below. These are just examples of special enrollment periods that are available. For the full list, you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
    - If you have moved out of your plan's service area
    - If you have Medicaid
    - If you are eligible for Extra Help with paying for your Medicare prescriptions
    - If we violate our contract with you
    - If you are getting care in an institution, such as a nursing home or long-term care hospital
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage.

Section 2.3 Where can you get more information about ending membership in a Medicare prescription drug plan?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this booklet).
- You can find the information in the *Medicare & You* 2014 handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the numbers below.
- You can contact **Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

SECTION 3 How do you end your membership in this plan?

You may request termination of this coverage by submitting an Enrollment/Disenrollment Form to your group benefits administrator. The effective date will be the first of the month after the form is received unless you stopped paying your premium and have exhausted your grace period before that date. If you enroll in another Part D plan, Medicare will terminate your coverage in this plan. Terminating just this plan will result in your enrollment in a Medical-Only plan that includes no prescription drug coverage. In order to cancel all participation in the State Retiree Health Benefits Program, you must submit a request to do so to your group benefits administrator unless you stop paying any premium.

SECTION 4 Until your membership ends, you must keep getting your drugs through this plan

Section 4.1 Until your membership ends, you are still a member of this plan

If you leave Express Scripts Medicare, it may take time before your membership ends and your new Medicare coverage goes into effect. (See **Section 2** for information on when your new coverage begins.) During this time, you should continue to get your prescription drugs through this plan as long as you remain eligible.

- **In order to have coverage through this plan until your new coverage starts, you should continue to pay your premium and use our network pharmacies to get your prescriptions filled until your membership in this plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our home delivery pharmacy services.

SECTION 5 Express Scripts Medicare must end your membership in certain situations

Section 5.1 When must we end your membership?

Express Scripts Medicare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of or are away from our service area for more than 12 months.
    - If you move or take a long trip, you need to call Customer Service (phone numbers are listed on the back of your member ID card and the front of this booklet) to find out if the place you are moving or traveling to is in this plan's service area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in this plan and that information affects your eligibility for this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay any plan premiums you are responsible for according to your group's premium payment policy.
    - The plan must notify you in writing that you have a grace period, which cannot be less than 2 calendar months, to pay the plan premium before we end your membership. Contact your group benefits administrator for more information about your plan premium and its grace periods for paying your plan premium.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from this plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, you can call **Customer Service** (phone numbers are listed on the back of your member ID card and the front of this booklet).

Section 5.2 We cannot ask you to leave this plan for any reason related to your health

Express Scripts Medicare is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave this plan because of a health-related reason, you should call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in this plan

If we end your membership in this plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in **Chapter 7, Section 7** for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don’t discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Express Scripts Medicare, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any State laws.

Chapter 10. Definitions of important words

2014 *Formulary (List of Covered Drugs)* or **Drug List** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs. This list contains the most commonly used covered drugs and does not include all Part D drugs covered by this plan.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. **Chapter 7** explains appeals, including the process involved in making an appeal.

Brand-name drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage stage – The stage in the Part D drug benefit where you usually pay a lower copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. **Chapter 2** explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if they apply). Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed copayment amount that a plan requires when a specific drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply (34-day supply) of certain drugs for you and you are required to pay a copayment.

Coverage determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the medication isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. **Chapter 7** explains how to ask us for a coverage decision.

Covered drugs – The term we use to mean all of the prescription drugs covered by this plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or retiree group) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later and have not experienced a 63 or more day break in creditable coverage.

Customer Service – A department within this plan responsible for answering your questions about your membership, benefits, and filing grievances. See the back of your member ID card and the front of this booklet for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $34 and a one-month's supply in your plan is 34 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before this plan begins to pay (if your plan has a deductible).

Disenroll or **Disenrollment** – The process of ending your membership in this plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug Tier (Cost-sharing Tier) – Each drug on our drug list is placed in a drug, or cost-sharing, tier – for example, Generic Drugs tier. The amount you pay as a copayment or coinsurance depends, in part, on which tier the drug is in. You can find more information about tiers in your 2014 *Formulary (List of Covered Drugs).*

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your eligibility record and any other attachments, riders, or enclosures, explains your Medicare drug coverage in general, what we must do, your rights, and what you have to do as a member of this Medicare prescription drug plan.

Exception – A type of coverage determination allowing you to request that a plan restriction or limit be waived for certain drugs. Examples include: allowing a different dosage or quantity of a drug, allowing you to use a drug without getting approval for it in advance, or allowing you to try a drug prescribed by your doctor that would normally require you to try a different drug first.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial coverage limit – The total drug cost under the Initial Coverage stage.

Initial Coverage stage – This is the stage after you have met your deductible (if any) and before your total drug expenses have reached $2,850, including amounts you've paid and what this plan has paid on your behalf. During this stage, you pay your share and the plan pays its share.

Late enrollment penalty (LEP) – An amount that may be added to your monthly premium for Medicare prescription drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See the **Appendix** for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease, also called ESRD (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In many cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage (MA-PD).** Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with ESRD (unless certain exceptions apply).

Medicare Annual Enrollment Period – A set time each fall when members can change their Medicare health or drug plans. The Medicare Annual Enrollment Period is from October 15 until December 7 every year.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a health maintenance organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap stage or total drug costs (yours and the plan's) of $2,850 and who are not already receiving Extra Help. Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, covered brand-name drugs are discounted.

Medicare health plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare prescription drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (member of this plan, or plan member) – A person with Medicare who is eligible to get covered services, who has enrolled in this plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the Federal government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with this plan to coordinate or provide covered drugs to members of this plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by this plan unless certain conditions apply.

Out-of-pocket costs – See the definition for "cost-sharing" at the beginning of this chapter. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket cost requirement. Your out-of-pocket costs are what move you toward the Catastrophic Coverage stage.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D drugs – Drugs that can be covered under Part D. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Please refer to your 2014 *Formulary (List of Covered Drugs)* or **Chapter 3** of this booklet for more information on what drugs are covered by this plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior authorization – A type of plan restriction requiring approval in advance to get certain drugs on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See the **Appendix** for information about how to contact the QIO in your state.

Quantity limits – A type of plan restriction on certain drugs that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the plan's service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, if we violate our contract with you, or if you leave this plan.

Step Therapy – A type of plan restriction on certain drugs that requires you to first try another drug to treat your medical condition before we will cover the drug your doctor may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Alabama	**State Health Insurance Assistance Program (SHIP)** **Alabama Department of Senior Services** 770 Washington Avenue RSA Plaza, Suite 570 Montgomery, AL 36130	toll-free: 1.877.425.2243 local: 1.334.242.5743 TTY: 1.334.242.0995
Alaska	**State Health Insurance Assistance Program (SHIP)** **Alaska Medicare Information Office** 550 West 8th Avenue Anchorage, AK 99501	toll-free: 1.800.478.6065 *(in-state calls only)* local: 1.907.269.3680 TTY: 1.800.770.8973
Arizona	**State Health Insurance Assistance Program (SHIP)** **DES Division of Aging and Adult Services** 1789 West Jefferson Street, Site Code 950A Phoenix, AZ 85007	toll-free: 1.800.432.4040 local: 1.602.542.4446 TTY: 1.602.542.6366
Arkansas	**Senior Health Insurance Information Program** **Arkansas Insurance Department** 1200 West Third Street Little Rock, AR 72201-1904	toll-free: 1.800.224.6330 local: 1.501.371.2782
California	**State Health Insurance Assistance Program (SHIP)** **California Health Insurance Counseling and Advocacy Program (HICAP)** 5380 Elvas Avenue, Suite 221 Sacramento, CA 95819	toll-free: 1.800.434.0222 local: 1.916.231.5110 TTY: 1.800.735.2929
Colorado	**Senior Health Insurance Assistance Program (SHIP)** 1560 Broadway, Suite 1550 Denver, CO 80202	toll-free: 1.888.696.7213 local: 1.303.894.7499 TTY: 1.303.894.7880
Connecticut	**CHOICES** **Department of Aging** 25 Sigourney Street, 10th Floor Hartford, CT 06106	toll-free: 1.800.994.9422 *(in-state calls only)* local: 1.860.424.5274 TTY: 1.800.842.4524
Delaware	**ELDERinfo** **Delaware Department of Insurance** 841 Silver Lake Boulevard Dover, DE 19904-2465	toll-free: 1.800.336.9500 local: 1.302.674.7364
District of Columbia	**Health Insurance Counseling Project (HICP)** 2136 Pennsylvania Avenue, NW Washington, D.C. 20052	local: 1.202.994.6272 local: 1.202.739.0668 TTY: 1.202.994.6656
Florida	**SHINE Program** **Florida Department of Elder Affairs** 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000	toll-free: 1.800.963.5337 local: 1.850.414.2000 TTY: 1.800.955.8770
Georgia	**GeorgiaCares** **Georgia DHS Division of Aging Services** 2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303-3142	toll-free: 1.866.552.4464 local: 1.404.657.5258 TTY: Georgia Relay 711

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Hawaii	**Sage PLUS Program/Hawaii SHIP** 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831	toll-free: 1.888.875.9229 local: 1.808.586.7299 TTY: 1.866.810.4379
Idaho	**Senior Health Insurance Benefits Advisors (SHIBA) of Idaho** **Idaho Department of Insurance** 700 West State Street P.O. Box 83720 Boise, ID 83720-0043	toll-free: 1.800.247.4422
Illinois	**Senior Health Insurance Program (SHIP)** **Illinois Department on Aging** 320 West Washington Street, 4th Floor Springfield, IL 62767	toll-free: 1.800.548.9034 *(in-state calls only)* local: 1.217.782.4515 TTY: 1.217.524.4872
Indiana	**State Health Insurance Assistance Program (SHIP)** **Indiana Department of Insurance** 714 West 53rd Street Anderson, IN 46013	toll-free: 1.800.452.4800 local: 1.765.608.2318
Iowa	**Senior Health Insurance Information Program (SHIIP)** 330 Maple Street Des Moines, IA 50319-0065	toll-free: 1.800.351.4664 TTY: 1.800.735.2942
Kansas	**Senior Health Insurance Counseling for Kansas (SHICK)** **Kansas Department for Aging and Disability Services** New England Building 503 South Kansas Avenue Topeka, KS 66603-3404	toll-free: 1.800.860.5260 local: 1.785.296.4986 TTY: 1.785.291.3167
Kentucky	**State Health Insurance Assistance Program (SHIP)** **Kentucky Cabinet for Health and Family Services** **Department for Aging and Independent Living** **Office of the Secretary** 275 East Main Street, 3E-E Frankfort, KY 40621	toll-free: 1.877.293.7447 local: 1.502.564.6930 TTY: 1.888.642.1137
Louisiana	**Senior Health Insurance Information Program (SHIIP)** **Louisiana Department of Insurance** 1702 North Third Street P.O. Box 94214 Baton Rouge, LA 70802	toll-free: 1.800.259.5300 local: 1.225.342.5301
Maine	**OADS Aging Services** **Maine Department of Health and Human Services** 11 State House Station 32 Blossom Lane Augusta, ME 04333	toll-free: 1.800.262.2232 local: 1.207.287.9200 TTY: Maine Relay 711

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Maryland	**Senior Health Insurance Assistance Program (SHIP)** **Maryland Department of Aging** 301 West Preston Street, Suite 1007 Baltimore, MD 21201-2374	toll-free: 1.800.243.3425 *(in-state calls only)* local: 1.410.767.1100
Massachusetts	**Serving Health Information Needs of Elders (SHINE)** **Executive Office of Elder Affairs** 1 Ashburton Place, 5th Floor Boston, MA 02108	toll-free: 1.800.243.4636 local: 1.617.727.7750 TTY: 1.800.872.0166
Michigan	**Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.)** 6105 West St. Joseph, Suite 204 Lansing, MI 48917-4850	toll-free: 1.800.803.7174 local: 1.517.886.0899
Minnesota	**Minnesota SHIP/Senior LinkAge Line** **Minnesota Board on Aging** P.O. Box 64976 St. Paul, MN 55164-0976	toll-free: 1.800.333.2433 TTY: 1.800.627.3529
Mississippi	**State Health Insurance Assistance Program (SHIP)** **Mississippi Department of Human Services** **Division of Aging and Adult Services** 750 North State Street Jackson, MS 39202	toll-free: 1.800.345.6347 local: 1.601.359.4929
Missouri	**CLAIM Program of Missouri** 200 North Keene Street, Suite 101 Columbia, MO 65201	toll-free: 1.800.390.3330 local: 1.573.817.8320
Montana	**Montana State Health Insurance Assistance Program (SHIP)** **Senior and Long Term Care** 2030 11th Avenue, P.O. Box 4210 Helena, MT 59604-4210	toll-free: 1.800.551.3191 local: 1.406.444.4077 TTY: 1.800.253.4093
Nebraska	**Nebraska Senior Health Insurance Information Program (SHIIP)** **Nebraska Department of Insurance** 941 O Street, Suite 400 Lincoln, NE 68508-3690	toll-free: 1.800.234.7119 local: 1.402.471.2201 TTY: 1.800.833.7352
Nevada	**State Health Insurance Assistance Program (SHIP)** 3416 Goni Road, Suite D-132 Carson City, NV 89706	toll-free: 1.800.307.4444 local: 1.702.486.3478
New Hampshire	**ServiceLink Aging and Disability Resource Center** **New Hampshire Department of Health and Human Services** 129 Pleasant Street Concord, NH 03301-3852	toll-free: 1.866.634.9412

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
New Jersey	**State Health Insurance Assistance Program (SHIP)** **New Jersey Department of Human Services** **Division of Aging Services** 240 West State Street Trenton, NJ 08625-1002	toll-free: 1.800.792.8820 *(in-state calls only)* toll-free: 1.877.222.3737
New Mexico	**Benefits Counseling Program** **New Mexico Aging and Long-Term Services Department** 2550 Cerrillos Road Santa Fe, NM 87505	toll-free: 1.800.432.2080 local: 1.505.476.4799 TTY: 1.505.476.4937
New York	**Health Insurance Information Counseling and Assistance Program (HIICAP)** **New York State Office for the Aging** 2 Empire State Plaza Albany, NY 12223-1251	toll-free: 1.800.701.0501 toll-free: 1.800.342.9871
North Carolina	**Seniors' Health Insurance Information Program (SHIIP)** **North Carolina Department of Insurance** 11 South Boylan Avenue Raleigh, NC 27603	toll-free: 1.800.443.9354 local: 1.919.807.6900 TTY: 1.919.715.0319
North Dakota	**State Health Insurance Counseling Program (SHIC)** **North Dakota Insurance Department** 600 East Boulevard Avenue Bismarck, ND 58505-0320	toll-free: 1.888.575.6611 local: 1.701.328.2440 TTY: 1.800.366.6888
Ohio	**Ohio Senior Health Insurance Information Program (OSHIIP)** **Ohio Department of Insurance** 50 West Town Street, Suite 300 Columbus, OH 43215	toll-free: 1.800.686.1578 local: 1.614.644.2658
Oklahoma	**Senior Health Insurance Counseling Program (SHIP)** **Oklahoma Insurance Department** 5 Corporate Plaza 3625 NW 56th Street, Suite 100 Oklahoma City, OK 73112-4511	toll-free: 1.800.763.2828 *(in-state calls only)* local: 1.405.521.6628
Oregon	**Senior Health Insurance Benefits Assistance (SHIBA)** 350 Winter Street NE, Suite 330 P.O. Box 14480 Salem, OR 97309-0405	toll-free: 1.800.722.4134 local: 1.503.947.7979 TTY: 1.800.735.2900
Pennsylvania	**APPRISE** **Commonwealth of Pennsylvania Department of Aging** 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	toll-free: 1.800.783.7067

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Puerto Rico	**State Health Insurance Assistance Program (SHIP)** P.O. Box 191179 San Juan, PR 00919-1179	toll-free (San Juan): 1.877.725.4300 local: 1.787.721.6121
Rhode Island	**Senior Health Insurance Program (SHIP)** **Rhode Island Department of Human Services** **Division of Elderly Affairs** 74 West Road Hazard Building, 2nd Floor Cranston, RI 02920	local: 1.401.462.3000 TTY: 1.401.462.0740
South Carolina	**Insurance Counseling Assistance and Referrals For Elders (I-CARE)** **Lieutenant Governor's Office on Aging** 1301 Gervais Street, Suite 350 Columbia, SC 29201	toll-free: 1.800.868.9095 local: 1.803.734.9900
South Dakota	**Senior Health Information and Insurance Education (SHIINE)** **South Dakota Department of Social Services** 700 Governors Drive Pierre, SD 57501	toll-free: 1.800.536.8197 local: 1.605.333.3314
Tennessee	**TN SHIP** **Tennessee Commission on Aging and Disability** **Andrew Jackson Building** 500 Deaderick Street, 8th Floor, Suite 825 Nashville, TN 37243-0860	toll-free: 1.877.801.0044 local: 1.615.741.2056 TTY: 1.800.848.0299
Texas	**Health Information Counseling and Advocacy Program (HICAP)** **Texas Department of Aging and Disability Services (DADS)** P.O. Box 149030 Austin, TX 78714-9030	toll-free: 1.800.252.9240 local: 1.512.438.3011 TTY: 1.800.735.2989
Utah	**Health Insurance Information Program (HIIP)** **Aging and Adult Services of Utah** 195 North 1950 West Salt Lake City, UT 84116	toll-free: 1.877.424.4640 local: 1.801.538.3910
Vermont	**State Health Insurance Assistance Program (SHIP)** 481 Summer Street, Suite 101 St. Johnsbury, VT 05819	toll-free: 1.800.642.5119 *(in-state calls only)* local: 1.802.748.5182
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)** **Virginia Division for the Aging** 1610 Forest Avenue, Suite 100 Henrico, VA 23229	toll-free: 1.800.552.3402 local: 1.804.662.9333 *(TTY available at both numbers)*

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Washington	**Statewide Health Insurance Benefits Advisors (SHIBA)** **Office of the Insurance Commissioner** P.O. Box 40255 Olympia, WA 98504-0255	toll-free: 1.800.562.6900 local: 1.360.725.7080 TTY: 1.360.586.0241
West Virginia	**West Virginia State Health Insurance Assistance Program (WV SHIP)** **West Virginia Bureau of Senior Services** 1900 Kanawha Boulevard East Charleston, WV 25305	toll-free: 1.877.987.4463 local: 1.304.558.3317 *extension 103*
Wisconsin	**State Health Insurance Assistance Program (SHIP)** **Department of Health Services** 1 West Wilson Street Madison, WI 53703-2118	toll-free: 1.800.242.1060 local: 1.608.246.7017 TTY: 1.888.701.1251
Wyoming	**Wyoming State Health Insurance Information Program (WSHIIP)** 106 West Adams Avenue P.O. Box BD Riverton, WY 82501	toll-free: 1.800.856.4398 local: 1.307.856.6880

Quality Improvement Organizations (QIOs)		
Alabama	**Alabama Quality Assurance Foundation (AQAF)** 2 Perimeter Park South, Suite 200 West Birmingham, AL 35243	local: 1.205.970.1600 toll-free: 1.800.366.1486
Alaska	**Mountain-Pacific Quality Health Foundation** 4241 B Street, Suite 101 Anchorage, AK 99503	local: 1.907.561.3202 toll-free: 1.877.561.3202
Arizona	**Health Services Advisory Group, Inc.** 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501	local: 1.602.264.6382 toll-free: 1.800.359.9909
Arkansas	**Arkansas Foundation for Medical Care (AFMC)** 1020 West 4th Street, Suite 300 Little Rock, AR 72201	local: 1.501.375.5700 toll-free: 1.877.375.5700
California	**Health Services Advisory Group of California, Inc.** 700 North Brand Boulevard, Suite 370 Glendale, CA 91203	local: 1.818.409.9229 toll-free: 1.866.800.8749
Colorado	**Colorado Foundation for Medical Care (CFMC)** 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708	local: 1.303.695.3300 toll-free: 1.800.950.8250
Connecticut	**Qualidigm** 1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067-3454	local: 1.860.632.2008 toll-free: 1.800.553.7590
Delaware	**Quality Insights of Delaware** Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812	local: 1.302.478.3600 toll-free: 1.866.475.9669
District of Columbia	**Delmarva Foundation of the District of Columbia (DFDC)** 2175 K Street NW, Suite 250 Washington, DC 20037	local: 1.202.293.9650 toll-free: 1.800.937.3362
Florida	**Florida Medical Quality Assurance, Inc. (FMQAI)** 5201 W. Kennedy Boulevard, Suite 900 Tampa, FL 33609-1822	local: 1.813.354.9111 toll-free: 1.800.844.0795
Georgia	**Alliant GMCF** 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346	local: 1.404.982.0411 toll-free: 1.800.982.0411
Hawaii	**Mountain-Pacific Quality Health - Hawaii** 1360 South Beretania Street, Suite 501 Honolulu, HI 96814	local: 1.808.545.2550 toll-free: 1.800.524.6550
Idaho	**Qualis Health** 720 Park Boulevard, Suite 120 Boise, ID 83712	local: 1.208.343.4617 toll-free: 1.800.488.1118
Illinois	**IFMC-IL (Telligen)** 700 Jorie Boulevard Oak Brook, IL 60523-4425	toll-free: 1.800.647.8089

Quality Improvement Organizations (QIOs)		
Indiana	**Health Care Excel, Inc.** 2901 Ohio Boulevard, Suite 112 Terre Haute, IN 47803	local: 1.812.234.1499 toll-free: 1.800.288.1499
Iowa	**Telligen** 1776 West Lakes Parkway West Des Moines, IA 50266	local: 1.515.223.2900 toll-free: 1.800.752.7014
Kansas	**Kansas Foundation for Medical Care** 2947 SW Wanamaker Drive Topeka, KS 66614-4193	local: 1.785.273.2552 toll-free: 1.800.432.0407
Kentucky	**Health Care Excel of Kentucky, Inc.** 1941 Bishop Lane, Suite 400 Louisville, KY 40218	local: 1.502.454.5112 toll-free: 1.800.288.1499
Louisiana	**eQHealth Solutions** 8591 United Plaza Boulevard, Suite 270 Baton Rouge, LA 70809	local: 1.225.926.6353 toll-free: 1.800.433.4958
Maine	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820	local: 1.603.749.1641 toll-free: 1.800.772.0151
Maryland	**Delmarva Foundation for Medical Care** 6940 Columbia Gateway Drive Suite 420 Columbia, MD 21046-2788	local: 1.410.822.0697 toll-free: 1.800.492.5811
Massachusetts	**Masspro** 245 Winter Street Waltham, MA 02451-1231	local: 1.781.890.0011 toll-free: 1.800.252.5533
Michigan	**Michigan Peer Review Organization (MPRO)** 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611	toll-free: 1.800.365.5899
Minnesota	**Stratis Health** 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525	local: 1.952.854.3306 toll-free: 1.800.444.3423 toll-free: 1.877.787.2847
Mississippi	**Information and Quality Healthcare** 385B Highland Colony Parkway, Suite 504 Ridgeland, MS 39157	local: 1.601.957.1575 toll-free: 1.800.844.0600
Missouri	**Primaris** 200 North Keene Street, Suite 101 Columbia, MO 65201	local: 1.573.817.8300 toll-free: 1.800.390.3330
Montana	**Mountain-Pacific Quality Health - Montana** 3404 Cooney Drive Helena, MT 59602	local: 1.406.443.4020 toll-free: 1.800.497.8232
Nebraska	**CIMRO of Nebraska** 1230 O Street, Suite 120 Lincoln, NE 68508	local: 1.402.476.1399 toll-free: 1.800.458.4262

Quality Improvement Organizations (QIOs)		
Nevada	**HealthInsight** 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118	local: 1.702.385.9933 toll-free: 1.800.748.6773
New Hampshire	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820	local: 1.603.749.1641 toll-free: 1.800.772.0151
New Jersey	**Healthcare Quality Strategies, Inc. (HQSI)** 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816	local: 1.732.238.5570 toll-free: 1.800.624.4557
New Mexico	**HealthInsight** 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109	local: 1.505.998.9898 toll-free: 1.800.663.6351
New York	**IPRO** 1979 Marcus Avenue Lake Success, NY 11042-1002	local: 1.516.326.7767 toll-free: 1.800.331.7767
North Carolina	**The Carolinas Center for Medical Excellence (CCME)** 100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598	local: 1.919.461.5500 toll-free: 1.800.682.2650
North Dakota	**North Dakota Health Care Review, Inc.** 3520 North Broadway Minot, ND 58703	local: 1.701.852.4231 toll-free: 1.888.472.2902
Ohio	**Ohio KePRO** Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131	local: 1.216.447.9604 toll-free: 1.800.589.7337
Oklahoma	**Oklahoma Foundation for Medical Quality** 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600	local: 1.405.840.2891 toll-free: 1.800.522.3414
Oregon	**Acumentra Health** 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201	local: 1.503.279.0100 toll-free: 1.800.344.4354
Pennsylvania	**Quality Insights of Pennsylvania** 2601 Market Place Street, Suite 320 Harrisburg, PA 17110	local: 1.717.671.5425 toll-free: 1.877.346.6180
Puerto Rico	**QIPRO, Inc.** City View Plaza, Tower 1, Suite 412 Road 165, Km 1.2, #48 Guaynabo, PR 00968	local: 1.787.641.1240 toll-free: 1.877.566.0566
Rhode Island	**Healthcentric Advisors** 235 Promenade Street Suite 500, Box 18 Providence, RI 02908	local: 1.401.528.3200 toll-free: 1.800.662.5028

Quality Improvement Organizations (QIOs)		
South Carolina	**The Carolinas Center for Medical Excellence (CCME)** 246 Stoneridge Drive, Suite 200 Columbia, SC 29210	local: 1.803.251.2215 toll-free: 1.800.922.3089
South Dakota	**South Dakota Foundation for Medical Care** 2600 West 49th Street, Suite 300 Sioux Falls, SD 57105	local: 1.605.336.3505 toll-free: 1.800.658.2285
Tennessee	**QSource** 3340 Players Club Parkway Memphis, TN 38125	toll-free: 1.800.528.2655
Texas	**TMF Health Quality Institute** Bridgepoint I, Suite 300 5918 West Courtyard Drive Austin, TX 78730-5036	local: 1.512.329.6610 toll-free: 1.800.725.9216
Utah	**HealthInsight** 756 East Winchester Street Suite 200 Salt Lake City, UT 84107	local: 1.801.892.0155 toll-free: 1.800.748.6773
Vermont	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820	local: 1.603.749.1641 toll-free: 1.800.772.0151
Virginia	**Virginia Health Quality Center (VHQC)** 9830 Mayland Drive, Suite J Richmond, VA 23233	local: 1.804.289.5320 toll-free: 1.800.545.3814
Washington	**Qualis Health** PO Box 33400 Seattle, WA 98133-0400	local: 1.206.364.9700 toll-free: 1.800.949.7536
West Virginia	**WVMI & Quality Insights** 3001 Chesterfield Avenue Charleston, WV 25304	local: 1.304.346.9864 toll-free: 1.855.886.0618
Wisconsin	**MetaStar, Inc.** 2909 Landmark Place Madison, WI 53713	local: 1.608.274.1940 toll-free: 1.800.362.2320
Wyoming	**Mountain-Pacific Quality Health - Wyoming** 145 South Durbin, Suite 105 Casper, WY 82601	local: 1.307.472.0507 toll-free: 1.877.810.6248

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Alabama	**Alabama Medicaid Agency** P.O. Box 5624 Montgomery, AL 36103-5624	local: 1.334.242.5000 toll-free: 1.800.362.1504
Alaska	**Alaska Department of Health and Social Services** 350 Main Street, Room 404 P.O. Box 110601 Juneau, AK 99811-0601	local: 1.907.465.3030
Arizona	**Arizona Health Care Cost Containment System (AHCCCS)** 801 East Jefferson Street, MD 4100 Phoenix, AZ 85034	local: 1.602.417.7000 toll-free: 1.800.962.6690
Arkansas	**Arkansas Department of Human Services** **Division of Medical Services** P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437	local: 1.501.682.8501 toll-free: 1.800.482.5431
California	**Medi-Cal** **Department of Health Care Services** P.O. Box 997417, MS 4607 Sacramento, CA 95899-7417	local: 1.916.552.9200
Colorado	**Department of Health Care Policy and Financing** 1570 Grant Street Denver, CO 80203	local: 1.303.866.3513 toll-free: 1.800.221.3943 *(outside Denver Metro Area)* TTY: 1.800.659.2656
Connecticut	**Department of Social Services** 25 Sigourney Street Hartford, CT 06106-5033	local: 1.860.424.4908 toll-free: 1.800.842.1508 TTY: 1.800.842.4524
Delaware	**Delaware Health and Social Services** **Division of Medicaid and Medical Assistance** 1901 North DuPont Highway, Lewis Building New Castle, DE 19720	local: 1.302.255.9500 toll-free: 1.800.372.2022
District of Columbia	**DC Department of Health Care Finance** 899 North Capitol Street NE, Suite 6039 Washington, DC 20002	local: 1.202.442.5988 *for eligibility questions:* local: 1.202.698.3900 local: 1.202.698.4350
Florida	**Florida Agency for Health Care Administration** 2727 Mahan Drive Tallahassee, FL 32308	toll-free: 1.888.419.3456
Georgia	**Georgia Department of Community Health** 2 Peachtree Street Northwest Atlanta, GA 30303	local: 1.404.656.4507 toll-free: 1.866.211.0950

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Hawaii	**Med-Quest Division** **Department of Human Services** 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817	local: 1.808.524.3370 toll-free: 1.800.316.8005
Idaho	**Idaho Department of Health and Welfare** P.O. Box 83720 Boise, ID 83720-0036	toll-free: 1.877.456.1233 TTY: 1.800.377.1363
Illinois	**Illinois Department of Healthcare and Family Services** 201 South Grand Avenue East Springfield, IL 62763-0001	local: 1.217.782.1200 toll-free: 1.800.226.0768 TTY: 1.877.204.1012
Indiana	**Family and Social Services Administration of Indiana** **Division of Family Resources** 402 West Washington Street, Room W-392 P.O. Box 7083 Indianapolis, IN 46204	local: 1.317.713.9627 toll-free: 1.800.889.9949 toll-free: 1.800.403.0864
Iowa	**Iowa Medicaid Enterprise** **Department of Human Services** **Member Services** P.O. Box 36510 Des Moines, IA 50315	local: 1.515.256.4606 toll-free: 1.800.338.8366
Kansas	**KanCare** 900 S.W. Jackson, Suite 900 Topeka, KS 66612-1220	toll-free: 1.866.305.5147 TTY: 1.800.766.3777
Kentucky	**Department for Medicaid Services** **Cabinet for Health and Family Services** **Office of the Secretary** 275 East Main Street Frankfort, KY 40621	local: 1.502.564.4321 toll-free: 1.800.635.2570
Louisiana	**Department of Health and Hospitals** P.O. Box 629 Baton Rouge, LA 70821-0629	toll-free: 1.888.342.6207
Maine	**Office of MaineCare Services** 11 State House Station Augusta, ME 04333-0011	local: 1.207.287.2674 toll-free: 1.800.977.6740 TTY: Maine Relay 711
Maryland	**Department of Health and Mental Hygiene** 201 West Preston Street Baltimore, MD 21201	local: 1.410.767.5800 toll-free: 1.800.456.8900 TTY: 1.800.735.2258
Massachusetts	**MassHealth Office of Medicaid** 1 Ashburton Place, 11th Floor Boston, MA 02108	local: 1.617.573.1770 toll-free: 1.800.841.2900 TTY: 1.800.497.4648

State Medicaid Offices
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

Michigan	**Michigan Department of Community Health** Capitol View Building 201 Townsend Street Lansing, MI 48913	local: 1.517.373.3740 TTY: 1.800.649.3777
Minnesota	**Department of Human Services** **Health Care Eligibility and Access Division** P.O. Box 64989 St. Paul, MN 55164-0989	local: 1.651.431.2670 toll-free: 1.800.657.3739 TTY: 1.800.627.3529
Mississippi	**Mississippi Division of Medicaid** Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201-1399	local: 1.601.359.6050 toll-free: 1.800.421.2408
Missouri	**The State of Missouri, MO HealthNet Division** 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500	local: 1.573.751.3425 toll-free: 1.800.392.2161 TTY: 1.800.735.2966
Montana	**Department of Public Health and Human Services** **Health Resources Division** 1400 East Broadway Street, Cogswell Building Helena, MT 59601-5231	local: 1.406.444.4540 toll-free: 1.800.362.8312
Nebraska	**Department of Health and Human Services** **Access Nebraska** P.O. Box 95026 Lincoln, NE 68509-5026	local: 1.402.471.3121 toll-free: 1.800.383.4278 TTY: 1.402.471.9570
Nevada	**Department of Health and Human Services** **Division of Health Care Financing and Policy** 1100 East William Street, Suite 101 Carson City, NV 89701	local: 1.775.684.3600 Las Vegas area: 1.702.668.4200 toll-free: 1.800.992.0900
New Hampshire	**Department of Health and Human Services** **Office of Medicaid Business and Policy** 129 Pleasant Street Concord, NH 03301	local: 1.603.271.4344 toll-free: 1.800.852.3345 *extension 4344* *(in-state calls only)* TTY: 1.800.735.2964
New Jersey	**Department of Human Services** **Division of Medical Assistance and Health Services** P.O. Box 712 Trenton, NJ 08625-0712	toll-free: 1.800.356.1561 *(in-state calls only)* TTY: 1.877.294.4356
New Mexico	**Human Services Department** **Medical Assistance Division** P.O. Box 2348 Santa Fe, NM 87504-2348	local: 1.505.827.3100 toll-free: 1.888.997.2583

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
New York	**New York State Department of Health** Corning Tower Empire State Plaza Albany, NY 12237	toll-free: 1.800.541.2831
North Carolina	**Department of Health and Human Services** **Division of Medical Assistance** 2501 Mail Service Center Raleigh, NC 27699-2501	local: 1.919.855.4100 toll-free: 1.800.662.7030
North Dakota	**Department of Human Services** **Medical Services Division** 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	local: 1.701.328.2321 toll-free: 1.800.755.2604 TTY: 1.800.366.6888
Ohio	**Department of Job and Family Services** 30 East Broad Street, 32nd Floor Columbus, OH 43215	toll-free: 1.800.324.8680
Oklahoma	**Oklahoma Health Care Authority** 2401 N.W. 23rd Street, Suite 1A Oklahoma City, OK 73107	local: 1.405.522.7171 toll-free: 1.800.522.0310 TTY: 1.800.757.5979
Oregon	**Oregon Health Plan** **Division of Medical Assistance Programs** 500 Summer Street, NE Salem, OR 97301-1079	local: 1.503.945.5772 toll-free: 1.800.527.5772 *(in-state calls only)* TTY: 1.800.375.2863
Pennsylvania	**Department of Public Welfare** **Office of Medical Assistance Programs** 2433 Jefferson Street Harrisburg, PA 17110	local: 1.717.787.3119 toll-free: 1.800.842.2020 TTY: 1.800.451.5886
Puerto Rico	**Medicaid Office** P.O. Box 70184 San Juan, PR 00936-8184	local: 1.787.765.1230 local: 1.787.641.4224
Rhode Island	**Department of Human Services** Louis Pasteur Building, #57 600 New London Avenue Cranston, RI 02920	local: 1.401.462.5300 TTY: 1.800.745.5555 *(in-state calls only)*
South Carolina	**Department of Health and Human Services** P.O. Box 8206 Columbia, SC 29202-8206	local: 1.803.898.2500 toll-free: 1.888.549.0820
South Dakota	**Department of Social Services** 700 Governors Drive Pierre, SD 57501	local: 1.605.773.4678 toll-free: 1.800.597.1603

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Tennessee	**TennCare Family Assistance Service Center** 310 Great Circle Road Nashville, TN 37243	local: 1.615.743.2000 toll-free: 1.866.311.4287 TTY: 1.877.779.3103
Texas	**Texas Health and Human Services Commission** Brown-Heatly Building 4900 North Lamar Boulevard, 4th Floor Austin, TX 78751-2316	local: 1.512.424.6500 toll-free: 1.800.252.8263 TTY: 1.800.735.2989
Utah	**Utah Department of Health** **Division of Medicaid and Health Financing** P.O. Box 143106 Salt Lake City, UT 84114-3106	local: 1.801.538.6155 toll-free: 1.800.662.9651
Vermont	**Department of Vermont Health Access** **Agency of Human Services** 312 Hurricane Lane, Suite 201 Williston, VT 05495	local: 1.802.879.5900 toll-free: 1.800.250.8427 TTY: 1.888.834.7898
Virginia	**Department of Medical Assistance Services** 600 East Broad Street, Suite 1300 Richmond, VA 23219-1857	local: 1.804.786.7933 toll-free: 1.800.643.2273 TTY: 1.800.343.0634
Washington	**Department of Social and Health Services** **Customer Service Center** P.O. Box 11699 Tacoma, WA 98411-9905	toll-free: 1.800.562.3022 TTY: 1.800.848.5429
West Virginia	**Department of Health and Human Resources** **Bureau for Medical Services** **MMIS Operations** 350 Capitol Street, Room 251 Charleston, WV 25301-3709	local: 1.304.348.3365 toll-free: 1.888.483.0797
Wisconsin	**Department of Health Services** 1 West Wilson Street, Room 350 Madison, WI 53703	local: 1.608.266.1865 toll-free: 1.800.362.3002 TTY: 1.888.701.1251
Wyoming	**Division of Healthcare Financing** 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002	local: 1.307.777.7531

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Colorado	**Bridging the Gap, Colorado** **AIDS Drug Assistance Program (ADAP)** **Colorado Department of Public Health and Environment** DCEED-STD-A3 4300 Cherry Creek Drive South Denver, CO 80246-1530	local: 1.303.692.2783
Connecticut	**Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)** **Connecticut Department of Social Services** 25 Sigourney Street Hartford, CT 06106	toll-free: 1.800.423.5026 out-of-state: 1.860.269.2029
Delaware	**Chronic Renal Disease Program (CRDP)** Milford State Service Center at Riverwalk 253 Northeast Front Street Milford, DE 19963	local: 1.302.424.7180 Delaware Help Line: 1.800.464.4357
Delaware	**Delaware Prescription Assistance Program** EDS DPAP P.O. Box 950 New Castle, DE 19720-0950	toll-free: 1.800.996.9969
Idaho	**Idaho AIDS Drug Assistance Program (IDAGAP)** **Department of Health and Welfare** 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036	local: 1.208.334.6657 toll-free: 1.800.926.2588
Indiana	**HoosierRx** P.O. Box 6224 Indianapolis, IN 46206-6224	local: 1.317.234.1381 toll-free: 1.866.267.4679
Maine	**Low Cost Drugs for the Elderly and Disabled Program (DEL)** **Office of Aging & Disability Services** **Maine Department of Health and Human Services** 11 State House Station 32 Blossom Lane Augusta, ME 04333	local: 1.207.287.9200 toll-free: 1.866.796.2463 TTY: Maine Relay 711
Maryland	**Maryland Senior Prescription Drug Assistance Program (SPDAP)** c/o Pool Administrators 628 Hebron Avenue, Suite 212 Glastonbury, CT 06033	toll-free: 1.800.551.5995 TTY: 1.800.877.5156
Maryland	**Kidney Disease Program of Maryland** 201 West Preston Street, Room SS-3 Baltimore, MD 21201	local: 1.410.767.5000

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Maryland	**Primary Adult Care Program (PAC)** P.O. Box 386 Baltimore, MD 21203	toll-free: 1.800.226.2142
Massachusetts	**Prescription Advantage** P.O. Box 15153 Worcester, MA 01615-0153	toll-free: 1.800.243.4636 TTY: 1.877.610.0241
Missouri	**Missouri Rx Plan** P.O. Box 6500 Jefferson City, MO 65102	toll-free: 1.800.375.1406 TTY: 1.800.375.1493
Montana	**Big Sky Rx Program** P.O. Box 202915 Helena, MT 59620-2915	toll-free: 1.866.369.1233 out-of-state & Helena: 1.406.444.1233
Montana	**Mental Health Services Plan** **Addictive and Mental Disorders Division** 555 Fuller Avenue, P.O. Box 202905 Helena, MT 59620-2905	local: 1.406.444.3964 toll-free: 1.888.866.0328
Montana	**AIDS Drug Assistance Program (ADAP)** **Department of Public Health** **and Human Services, HIV/STD Section** Cogswell Building C-211, P.O. Box 202951 Helena, MT 59620	local: 1.406.444.4744
Nevada	**Nevada Senior Rx/Disability Rx** **Department of Health and Human Services** 3416 Goni Road, Suite B-113 Carson City, NV 89706	local: 1.775.687.4210 *(Reno, Carson City, Gardnerville)* toll-free: 1.866.303.6323
New Jersey	**Pharmaceutical Assistance to the Aged** **and Disabled Program (PAAD)** **Senior Gold Prescription Discount Program** **Division of Aging Services** **Department of Human Services** P.O. Box 715 Trenton, NJ 08625-0715	toll-free: 1.800.792.9745
New York	**Elderly Pharmaceutical Insurance Coverage (EPIC)** P.O. Box 15018 Albany, NY 12212-5018	toll-free: 1.800.332.3742 TTY: 1.800.290.9138
North Carolina	**North Carolina HIV SPAP** 1902 Mail Service Center Raleigh, NC 27699	local: 1.919.733.7301 toll-free: 1.877.466.2232 *(in-state calls only)*
Pennsylvania	**The Chronic Renal Disease Program** **Pennsylvania Department of Health** **Division of Child and Adult Health Services** 625 Forster Street, 7th Floor, East Harrisburg, PA 17120-0701	toll-free: 1.800.225.7223

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Pennsylvania	**PACE/PACENET Program** **Pennsylvania Department of Aging** **Bureau of Pharmaceutical Assistance** 555 Walnut Street Harrisburg, PA 17101	local: 1.717.787.7313 toll-free: 1.800.225.7223
Pennsylvania	**Special Pharmaceutical Benefits Program – HIV/AIDS** P.O. Box 8021 Harrisburg, PA 17105	toll-free: 1.800.922.9384
Rhode Island	**Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)** Attention: RIPAE, Division of Elderly Affairs 74 West Road, Hazard Building, 2nd Floor Cranston, RI 02920	local: 1.401.462.3000 TTY: 1.401.462.0740
Texas	**Kidney Health Care Program** **Department of State Health Services** P.O. Box 149347, MC 1938 Austin, TX 78714-9347	local: 1.512.458.7150 toll-free: 1.800.222.3986
Texas	**Texas HIV State Pharmaceutical Assistance Program (SPAP)** **Department of State Health Services – HIV/STD Program** P.O. Box 149347, MC 1873 Austin, TX 78714	local: 1.512.533.3000 toll-free: 1.800.255.1090 *extension 3004*
Vermont	**VPharm/VSCRIPT Expanded Vermont Health Access Plan (VHAP - Pharmacy)** **Healthy Vermonters** 312 Hurricane Lane, Suite 201 Williston, VT 05495	local: 1.802.879.5900 toll-free: 1.800.250.8427 TTY: 1.888.834.7898
Virginia	**Virginia AIDS Drug Assistance Program (ADAP) and Virginia HIV SPAP** Patient Services Incorporated P.O. Box 5930 Midlothian, VA 23112	toll-free: 1.800.366.7741
Wisconsin	**Wisconsin Chronic Disease Program (Chronic Renal Disease, Cystic Fibrosis, and Hemophilia Home Care Programs)** P.O. Box 6410 Madison, WI 53716-0410	toll-free: 1.800.362.3002
Wisconsin	**Wisconsin SeniorCare** P.O. Box 6710 Madison, WI 53716-0710	toll-free: 1.800.657.2038

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